SUMMARY OF NO. 15-19

This proposed law would regulate the payments made by any non-government health insurance plan to health care providers for each medical service such that those payments would be no more than 20% above or 10% below the average price paid to all such providers by that health plan for that medical service. The proposed law defines "health care provider" as an acute-care hospital and its contracting agents.

The proposed law would require each health plan to calculate the relative price that it has agreed to pay health care providers for each medical service on a statewide basis and by provider type. A "relative price" is generally calculated by dividing the price paid to a particular provider for a medical service by the average price paid to all providers for that service. Health plans would report their relative prices to the state Division of Insurance on an annual basis, and the Division would publish this relative price data.

The proposed law would prohibit any health plan from entering into or renewing any contract with a provider under which the provider would be paid a price for a medical service greater than 20% above the average relative price paid by that health plan for that service. This provision would not apply to specialty hospitals (such as pediatric or oncology hospitals), geographically isolated hospitals (defined as the sole acute-

care hospital within a 20-mile radius), and hospitals that derive at least 63% of their patient revenue from government programs like Medicare and Medicaid.

The proposed law would also prohibit any health plan from entering into or renewing any contract with a health care provider where the provider is paid a price for a service that is less than 10% below the average relative price paid by that plan for that service.

The proposed law would take effect on January 15, 2017, but would apply to contracts entered into or renewed after July 1, 2016.

The proposed law would require providers to furnish covered services as a condition of licensure and to accept payments consistent with the proposed law. Providers would be prohibited from billing the recipient of services for any additional amounts the provider would have received without the proposed law. Providers could not refuse to participate in a health plan's provider network due to the plan's compliance with the law. If a provider does not participate in a health plan's network, but provides out-of-network services, it would have to accept payment at the health plan's average relative price.

The proposed law would require any net savings realized by health plans attributable to this proposed law, beyond the cost of complying with its price regulations, to be reflected in

reduced health plan premiums, co-pays, and deductibles charged to the plan's subscribers and would require the Division of Insurance to issue regulations concerning this requirement.

The proposed law would prohibit providers whose prices are reduced as a result of the proposed law from charging more to other health plans or payers as a result and would authorize the state Attorney General to issue regulations on this point.

The proposed law would establish a process for providers to apply to the Division of Insurance for an annual exemption. The Division could consider, among other things, health care costs, the financial condition of the provider, and patient access to the provider's services.

The proposed law would require the Division of Insurance to annually publish hospital price information as well as quality scores for hospitals. The proposed law also would require the Division to conduct an annual study on the impact of the proposed law.

The proposed law states that, if any of its parts were declared invalid, the other parts would stay in effect.